



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
 WIC AND NUTRITION SERVICES  
**NUTRITION ASSESSMENT FOR WOMEN**

PARTICIPANT NAME AND DCN	DATE OF BIRTH	CATEGORY P / B / N	DATE COMPLETED
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Form completed by:  Participant or WIC Staff:  CPA  RD  Nutritionist  WIC Certifier

Please think about your usual eating pattern and answer the following questions to the best of your ability.  
 Place a check mark in the box  and/or **write-in** your answer.

**MEAL PATTERN (This section is to be completed for all Women)**

1. How many times a day do you eat? \_\_\_\_\_ meals/day \_\_\_\_\_ snacks/day  
 What type foods do you typically snack on? Check all that apply.  
 Milk, yogurt, cheese       Meat, fish, eggs, beans       Fruits or vegetables       Other:  
 Bread, cereal, rice and pasta       Chips/salty foods       Cookies/cakes/sugary foods

2. In a typical week, how many meals do you eat from a restaurant, including fast food? \_\_\_\_\_ meals/week

3. How many days a week does your family usually eat a meal together? \_\_\_\_\_ days/week  Does not apply (single)

4. Is there anything you would like to change about the food you eat? .....  Yes  No  
 List changes:

**EATING PATTERN (This section is to be completed for all Women)**

5. How are most foods prepared? Check all that apply.  
 Baked  Fried  Boiled  Roasted  Broiled  Grilled  Microwaved

6. Are there any foods that you think you don't eat enough of? .....  Yes  No  
 If yes, check all that apply.  
 Milk, yogurt, cheese  Meat, fish, eggs, beans  Fruits  Vegetables  Bread, cereal, rice and pasta

\*7. Are you following a special diet? [340 427.2] .....  Yes  No  
 If yes, check type.  
 Vegetarian  Vegan  Low calorie/weight loss  Macrobiotic  Food allergy or intolerance  
 Low Fat  Low carbohydrate  Other:

\*8. Some women crave non-food items. Do you eat any of these items? [427.3] .....  Yes  No  
 If yes, check all that apply.  
 Ashes  Chalk  Large quantities of ice and/or freezer frost  Other:  
 Baking Soda  Cigarettes  Paint Chips  
 Burnt Matches  Clay  Soil  
 Carpet fibers  Dust  Starch (laundry or cornstarch)

**BEVERAGES (This section is to be completed for all Women)**

9. Do you drink milk? .....  Yes  No  
 If yes, check type.  
 Fat-free (skim)  Low-fat (1%)  Reduced fat (2%)  Whole  Rice Milk  
 Soy Milk  Powdered  Evaporated  Sweetened Condensed  Goat's milk  
 Other:

10. How often do you drink milk? Check one.  
 Several times/day  Once/day  Less than once/day

11. How often do you eat other dairy foods such as cheese, yogurt, or pudding?  
 Several times/day  Once/day  Less than once/day

12. What other beverages do you drink in a typical day? Check all that apply.  
 Juice  Water  Fruit drinks  Sports drinks  Regular pop/soda  Diet pop/soda  Coffee/tea  
 Beer  Wine  Other alcoholic drinks  Other:

13. What is your main source of drinking water? Check one.
- City water system    Rural water system    Private well    Bottled water
- a. If private well, has it been tested for bacteria or nitrates? .....  Yes    No    Don't know  
 If yes, check results:    Safe    Unsafe    Don't know
- b. Do you know if your water is fluoridated? .....  Yes    No    Don't know
- c. Do you brush your teeth with toothpaste that has fluoride? .....  Yes    No    Don't know

**SUPPLEMENTS (This section is to be completed for all Women)**

14. Did you take a multivitamin in the month before your most recent pregnancy? [427.4] .....  Yes    No  
 If yes, how many times a week? \_\_\_\_\_ times/week

15. Have you taken any vitamins, minerals, herbs or herbal supplements in the past month or currently? [427.1 427.4]    Yes    No  
 If yes, check all that apply.  
 Prenatal vitamin    Multivitamin (not a prenatal)    Iron Supplement    Herbal Supplement  
 Others:

16. Do you use iodized salt? .....  Yes    No

**FOOD SAFETY (This section is to be completed for all Women)**

17. Do you have adequate equipment for food storage and preparation such as a refrigerator, a stove that works, and storage free from pests and harmful chemicals? .....  Yes    No

**FOOD SECURITY AND PROGRAM PARTICIPATION (This section is to be completed for all Women)**

18. In the past month, did you or anyone in your household ever eat less than you felt you should or not eat for a whole day because there wasn't enough money for food? .....  Yes    No    Don't know or refused

19. Are you participating in any food and nutrition program? .....  Yes    No  
 If yes, check all that apply.  
 Food Stamps    School Lunch    Family Nutrition Education Program (FNEP)    Commodity Program  
 Food Pantry    Other:

**PHYSICAL ACTIVITY (This section is to be completed for all Women)**

20. In a typical day, how many **minutes** are you physically active?    None    1-30    31-60    More than 60

**PREGNANCY (Complete this section only if you are currently pregnant)**

21. How much weight do you think you should gain with this pregnancy?   \_\_\_\_\_ Pounds    No Idea
22. Are you having any of the following problems? .....  Yes    No  
 If yes, check all that apply.  
 Constipation    Diarrhea    Nausea    Vomiting    Heartburn    Other:

- \*23. Do you eat foods such as: [427.5]
- a. raw fish or shellfish .....  Yes    No
- b. refrigerated smoked seafood .....  Yes    No
- c. raw or undercooked meat, chicken or turkey .....  Yes    No
- d. uncooked luncheon meats, deli meats, hot dogs .....  Yes    No
- e. refrigerated pate or meat spreads .....  Yes    No
- f. unpasteurized milk or foods containing unpasteurized milk .....  Yes    No
- g. soft cheeses such as Feta, Brie, Camembert, blue-veined cheese, Mexican-style cheese .....  Yes    No
- h. raw or undercooked eggs or foods containing raw or lightly cooked eggs .....  Yes    No
- i. raw vegetable sprouts such as alfalfa, clover and radish .....  Yes    No
- j. unpasteurized fruit or vegetable juices .....  Yes    No

**BREASTFEEDING (Complete this section only if you are currently breastfeeding)**

24. Do you have any concerns related to breastfeeding? [602] .....  Yes    No  
 If yes, list concerns:

**TO BE COMPLETED BY WIC OFFICE PERSONNEL ONLY**

SIGNATURE (RISK ASSESSMENT)		SIGNATURE (NUTRITION COUNSELING)	
DATE	TITLE	DATE	TITLE